Billing Basics

Claim Submission

All claims, whether electronic or paper, are subject to the same Medicaid processing and legal requirements.

Electronic Billing

Providers are encouraged to submit claims electronically. Electronic claims submission:

- Reduces processing time.
- Eliminates manual handling of claims.
- Reduces both billing and processing errors.

Wisconsin Medicaid provides free software for billing electronically. For more information on electronic billing:

- Refer to the Claims Submission section of the All-Provider Handbook.
- Contact the Electronic Media Claims (EMC) Department at (608) 221-4746. Ask to speak with an EMC coordinator.

If you are currently using the free software and have technical questions, please contact Wisconsin Medicaid's customer service at (800) 822-8050.

Paper Claim Submission

Providers submitting paper claims must use the HCFA 1500 claim form (dated 12/90). Refer to Appendix 2 of this handbook for HCFA 1500 claim form completion instructions and Appendices 3 and 4 of this handbook for sample completed claim forms.

Wisconsin Medicaid denies claims for services submitted on any paper claim form other than the HCFA 1500 claim form.

Wisconsin Medicaid does not provide the HCFA 1500 claim form. You may obtain the form from any vendor that sells federal forms.

Where to Send Your Claims

Mail completed HCFA 1500 claim forms for reimbursement to the following address:

Wisconsin Medicaid
Claims and Adjustments Unit
6406 Bridge Road
Madison, WI 53784-0002

Claim Submission Deadline

Wisconsin Medicaid must receive properly completed claims within 365 days from the date the service was provided.

Wisconsin Medicaid must receive properly completed claims within 365 days from the date the service was provided. This policy applies to all initial claim submissions, resubmissions, and adjustment requests.

Exceptions to the 365-day claim submission deadline and requirements for submission to Late Billing Appeals can be found in the Claims Submission section of the All-Provider Handbook. Providers may access the handbook on-line at *www.dhfs.state.wi.us/medicaid/*. If you wish to make adjustments, refer to Appendices 5, 6, and 7 of this handbook.

Billed Amounts

Providers are required to bill their usual and customary charge for the service performed. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to Wisconsin Medicaid benefits. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid patients.

Providers may not discriminate against Wisconsin Medicaid recipients by charging

Medicaid a higher fee for the same service than that charged to a private pay patient. For providers that have not established usual and customary charges, the charge should be reasonably related to the provider's cost to provide the service.

Reimbursement

Wisconsin Medicaid reimburses certified registered nurse anesthetists (CRNAs) and anesthesiologist assistants (AAs) based on the type of service performed, time spent in anesthesia, and the level of medical direction provided. The level of medical direction is indicated by a modifier. (Refer to Appendix 1 of this handbook for a list of the Medicaid-allowed modifiers and their descriptions.)

Wisconsin Medicaid's usual reimbursement for anesthesia is equal to the lesser of either the billed amount or the amount calculated by the following formula:

(RVUs + time units) x modifier coefficient

That is, the relative value units (RVUs) for the major procedure (assigned automatically by Medicaid), plus the number of 15-minute time units, multiplied by a specific coefficient amount for the modifier billed.

The RVU assigned to each procedure code and the modifier coefficient amount for each of the modifiers allowed for CRNAs and AAs is indicated on the Wisconsin Medicaid maximum allowable fee schedule for physician services.

Since the RVU includes usual pre- and post-operative care, the administration of the anesthetic, and incidental administration of fluids and/or blood, Wisconsin Medicaid will not reimburse these services in addition to the reimbursement for anesthesia.

Invasive monitoring and *vascular procedures* are reimbursed the lesser of either the billed amount or the quantity multiplied by Wisconsin Medicaid's maximum allowable fee for the procedure.

Example: A CRNA or AA bills $143 for a surgical procedure that has an RVU of 4.00. The surgery lasted an hour and three-quarters, which translates to a billed quantity of 7.0. By using modifier WD, the coefficient amount is $11.04. According to the reimbursement formula, the Medicaid reimbursement would be calculated as follows:

(4+7) x $11.04 = $121.44
i.e., (RVUs + time units) x modifier coefficient = Medicaid reimbursement

Since $121.44 is less than the billed amount, the CRNA or AA's reimbursement would be $121.44.

Differences from Medicare

Wisconsin Medicaid's reimbursement calculation process differs from Medicare in the following ways:

- Time is calculated in units, rather than minutes.
- The RVUs are incorporated in the formula. Do not bill these separately.
- Medicaid codes, modifiers, and RVUs may differ from Medicare.

Maximum Allowable Fee Schedule

The Wisconsin Medicaid maximum allowable fee schedule for *physician* services includes the following information for CRNAs and AAs:

- Maximum allowable fees for invasive monitoring and vascular procedures.
- The RVU assigned to surgical procedures.
- The current coefficient amount for each modifier.

To obtain a maximum allowable fee schedule, use one of the following methods:

- Purchase a paper schedule by writing to:

  Wisconsin Medicaid
  Provider Maintenance
  6406 Bridge Road
  Madison, WI 53784-0006

Invasive monitoring and vascular procedures are reimbursed the lesser of either the billed amount or the quantity multiplied by Wisconsin Medicaid's maximum allowable fee for the procedure.

- Download an electronic version from Wisconsin Medicaid's Web site using directions located in the Claims Submission section of the All-Provider Handbook. Wisconsin Medicaid's Web site is located at *www.dhfs.state.wi.us/medicaid/*.

Follow Up to Claim Submission

The All-Provider Handbook includes the appropriate procedures for claim follow up, including:

- The Remittance and Status (R/S) Report.
- Adjustments to paid claims (refer to Appendices 5, 6, and 7 for the Adjustment Request Form completion instructions, a completed sample form, and a blank form for photocopying).
- Return of overpayments.
- Duplicate payments.